TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BRYCE I. BENBOW, DO

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-14-2575-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
APRIL 21, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have attached all documentation for your review."

Amount in Dispute: $17,731.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Provider Billed CPT 63056…when the documentation supports CPT 62287…CPT 63710 was billed for placement of a dural graft; however, the operative report does not support this description of service as the operative report notes injected amniotic membrane, where no dural graft was placed. CPT 77003 is considered inclusive to CPT 62287 and is not separately reimbursable."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 20, 2013	CPT Code 63056	$11,859.00	$3,018.18
	CPT Code 63710	$5,590.00	$1,124.97
	CPT Code 77003-26	$282.00	$49.22
TOTAL		$17,731.00	$4,192.37

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - X263-The code billed does not meet the level/description of the procedure performed/documented. Consideration will be given with coding that reflects the documented procedure.
   - X901-Documentation does not support level of service billed.
   - B291-This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - X598-Claim has been re-evaluated based on additional documentation submitted; no additional payment due.

Issues

1. Does the documentation support billing CPT code 63056?
2. Does the documentation support billing CPT code 63710?
3. Is the allowance of CPT code 77003-26 included in the allowance of another service/procedure billed on the disputed date of service?

Findings

1. According to the explanation of the respondent denied reimbursement for CPT code 63056 based upon reason code "X263."

   28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   CPT code 63056 is defined as "Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)."

   The Operative Report indicates that claimant underwent the following procedures:

   - Transforaminal diskectomy at L5-S1 on the right;
   - Application of DuraGraft, L5-S1 on the right; and
   - Intraoperative fluoroscopy.

   The Division finds that the requestor wrote "The skin incision was made and a blunt dilator was used to diate down over the guidewire to the disk herniation. The dilator was docked on the formainal disk herniation at L5-S1 on the right. The dilator was impacted into the disk several millimeters after the annulus had been anesthetized with 0.5% Xylocaine. The joimax endoscope was then used to aid in the diskectomy. Under direct visualization, the disk herniation was removed with pituitaries, both straight and bitins as well as a shaver. The disk herniation in the foramen was further decompressed. …The annulus was then cauterized with monopolar cauter;y to further shrink any fenestrations of the annulus. With direct visualization, the nerve roots were decompressed." The documentation supports billing; therefore, reimbursement is recommended.

2. According to the explanation of the respondent denied reimbursement for CPT code 63710 based upon reason code "X901."

   CPT code 63710 is defined as "Dural graft, spinal."
   Based upon the Operative Report the "thecal sac and nerve root were then injected with liquid amniotic membrane." The requestor supported billing code 63710; therefore, reimbursement is recommended.

3. According to the explanation of the respondent denied reimbursement for CPT code 77003-26 based upon reason code "B291".

   28 Texas Administrative Code §134.203(b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

Per CCI edits, CPT code 77003-26 is not a component of any other service rendered on the disputed date; therefore, the respondent's denial based upon reason code "B291" is not supported.

4. Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2013 DWC conversion factor for this service is 69.43.

The Medicare Conversion Factor is 34.023

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75231, which is located in Dallas, Texas; therefore, the Medicare participating amount is based on locality "Dallas, Texas".

Using the above formula, the Division finds the following:

Code	Medicare Participating Amount	MAR	Respondent Paid	Total Amount Due
63056	$1,479.01	$3,018.18	$0.00	$3,018.18
63710	$1,102.55	$1,124.97	$0.00	$1,124.97
77003-26	$30.28	$49.22	$0.00	$49.22

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $4,192.37.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $4,192.37 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	07/09/2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.